This benefit summary is intended to help you compare coverage and benefits and is a summary only. For a more detailed description of coverage, benefits, and limitations, including any related exclusions not contained in this benefit summary, please contact the health care service plan or health insurer and consult the individual plan's evidence of coverage. The comparative benefit summary is updated annually, or more often if necessary to be accurate. The most current version of this comparative benefits summary is also available on uhphealthcare.com . However, the plan may simply provide a link to this website and the DMHC's version of this matrix. You may contact the Department of Managed Health Care at (888) HMO-2219 for further assistance regarding the matrix.

Plan Name **Watts Health Foundation, Inc.**	**Plan Contact Phone Number** **800 847-1222**
Coverage summary	
Eligibility requirements	You are eligible to enroll in the Post-MRMIP Graduate Product if you meet any of the following criteria: · Apply for coverage within 63 days of the termination date of previous coverage under the MRMIP and have had continuous coverage under the MRMIP for a period of 36 consecutive months, or · Have been enrolled in a Post-MRMIP standard benefit plan and move to an area within the state that is not in the service area of the plan or insurer you previously selected and you apply for coverage within 63 days of termination of previous coverage, or · Have been enrolled in a Post-MRMIP standard benefit plan that is no longer available where you reside and apply for coverage within 63 days of the termination date of the previous coverage · Plans may decline coverage if you are eligible for parts A and B of Medicare at the time of application and are not enrolled in Medicare solely due to end stage renal disease. Dependent Coverage-The following dependents may also be enrolled: Subscriber's spouse, Subscriber or spouse's unmarried children; dependent children over age 23 incapable of self-sustaining employment due to certain disabilities. (Consult the Plan's Evidence of Coverage for further information as availability of dependent coverage varies).
The full premium cost if each benefit package in the service area in which the individual and eligible dependents work or reside	Premiums charged by plans vary by region and age of subscribers. See Post-MRMIP Graduate Product Rate Chart on this website.
When and under what circumstances benefit cease	Coverage may be terminated by the Plan under the following circumstances: · Loss of eligibility by Subscriber or enrolled dependents, including (1) Subscriber or Dependent(s) move out of the Plan's service area (Please contact the Plan for further details regarding the process for selection of a different Post-MRMIP Graduate Product under such circumstances) or out of California or (2) Enrolled dependents no longer meet eligibility requirements. · Termination of Plan type by Plan in which Subscriber or Dependents is enrolled (Please contact the Plan for further details regarding the process for selection of a different Post-MRMIP Graduate Product under such circumstances) · Non-payment of subscription charges · Fraud or material misrepresentation (This list represents a general summary. Please consult the Plan's Evidence of Coverage for specific details regarding causes for termination by the Plan).

The terms under which coverage may be renewed	Coverage under the Plan shall continue, except under the following circumstances: · Loss of eligibility by Subscriber or by enrolled Dependents · Non-payment of subscription charges · Fraud or material misrepresentation · Termination of plan type by Plan in which Subscriber or Dependents is enrolled (Please contact the Plan for further details regarding the process for selection of a different Post-MRMIP Graduate Product under such circumstances) · Subscriber moves out of the service area
Other coverage that may be available if benefits under the described benefit package cease	"Individual coverage is available when coverage terminates because of divorce, death of Subscriber, loss of custody of dependent child, or for overaged dependents. Such coverage is not available if terminated for failure to pay premiums, good cause, fraud, or if the member is covered or eligible under a government or group plan. Also such coverage is not available to persons who are covered under an individual plan or for persons not continuously covered under the Plan for three months before termination."
The circumstances under which choice in the selection of physicians and providers is permitted	Members are encouraged to choose a primary care Plan Physician from a list of available Plan Physicians in the following specialties: internal medicine, obstetric/gynecology, family practice, and pediatrics. Members may change their primary care Plan Physician at any time.

Coverage Summary

Lifetime and annual maximums	$ 200,000 Calendar Year Maximum $ 750,000 Lifetime Maximum
Deductibles	None

Benefit Summary (*1)		**Co-payments** Calendar Year Copayment Maximum out of pocket. Copayment Limit is $2,500 for one member and $4,000 for a member and all covered dependents.	**Limitation**
Professional Services	Physician office visits, including , but not limited to preventive care, immunizations, screenings and diagnostic visits.		
	Doctor Office Visit	$20.00	
	Pediatric Visits	$20.00	
	Physical Exams	$20.00	
	Vision Exams (0 - 17 years)	$20.00	
	Hearing Exams	$20.00	
	Scheduled Well Baby Visits (0 - 23 months)	$15.00	
	Scheduled Prenatal Visit and first Post-Partum Visit	$15.00	
	Immunizations	$0.00	
	Family Planning	$20.00	

Outpatient Services	Outpatient services, including, but not limited to, surgery and treatment, and diagnostic procedures.		
	Outpatient Surgery	$100.00	
	Voluntary Sterilization	$100.00	
	Abortion	$100.00	
	Physical, Speech, and Occupational Therapy	$20.00	
	Multidisciplinary Rehabilitation	$20.00	
	Lab (pap smears included)	$5.00	
	Imaging (mammographies included)	$5.00	
	Other Tests & Procedures	$5.00	
	Dermatology (UV light treatment)	$5.00	
	Health Education Classes	$20.00	
	Allergy Injection	$3.00	
	Allergy Testing	$20.00	
Hospitalization Services	Inpatient and outpatient services, including but not limited to room and board and supplies.		
	Inpatient - Hospital,	$200.00 per inpatient day	
	Inpatient - Multi-disciplinary Rehabilitation Services (These are intense coordinated rehabilitation services in more that one therapy, including, but not limited to therapy services provided following a stroke or spinal cord injury)	$200.00 per inpatient day	
	Inpatient - Maternity	$200.00 per inpatient day	
Emergency Health Coverage	Emergency room services at contracted and non-contracted facilities for medically necessary emergencies.	$100.00 (waived if admitted) (If admitted, hospitalization copayments apply)	

Benefit Summary Cont.		**Co-payments**	**Limitation**
Ambulance Services	Emergency ambulance transport.	$75.00	

Prescription Drug Benefits	Medically necessary drugs prescribed by a physician.		Drugs, supplies, and supplements are covered when prescribed by a Plan Physician and in accord with our drug formulary guidelines. Certain drugs are covered only for a 30-day supply in a 30 day period.
	100 Days Supply (Generic/Brand) Sexual Dysfunction Drugs	$10/$35 50% of Charges	
Durable Medical Equipment	Home medical equipment, including, but not limited to, oxygen, parenteral and enteral nutrition, colostomy supplies, corrective prosthetics and aids, and diabetic supplies. Includes Durable Medical Equipment, Supplies, Prosthetic Devices, and Braces. Other items listed above may be covered under other benefit categories. Items used during covered Hospital stay or Skilled Nursing Facility Items used at home	 $0.00 20% of Charges	 Durable Medical Equipment is covered in accord with our DME formulary guidelines.
Mental Health Services	Inpatient and outpatient mental health services, including, but not limited to, mental health parity services **(**2)** for serious mental disorders and severe emotional disturbances for children.		
	Outpatient - Individual Therapy Outpatient - Group Therapy Inpatient	$20.00 $10 $200 per inpatient day	Up to a total of 15 individual and group therapy visits each calendar year Up to 10 days per calendar year Visits and Day Limits do not apply to mental health parity conditions
Residential treatment	Transitional Residential Recovery Services.	Not covered	
Chemical Dependence Services	Substance abuse treatment or rehabilitation. In the Hospital Outpatient Treatment Services Transitional Residential Recovery Services	 $200 copay per inpatient day Not covered Not covered	
Home Health Services	Home Health and hospice care services **(***3)** Hospice Care Home Health Care	 $0.00 $0.00	Part-time or intermittent home health covered up to: - Up to 2 hours per visit - Up to 3 visits per day -Up to 100 visits per calendar year
Custodial care and skilled nursing facilities.	Skilled nursing care and skilled nursing facilities services. Custodial Care	$0.00 Not covered	100 days per benefit period

(*1) For participating providers, percentage co-payments represent a percentage of actual cost, or, if the plan pays the provider a per-member-per-month rate, an equivalent cost. Percentage co-payments for services provided by non-participating providers are a percentage of usual, customary or reasonable rates, negotiated costs, or billed charges, as determined by the plan. (Please consult the Evidence of Coverage). In a PPO, enrollees are also responsible for any excess amount billed by a non-participating provider.

(2)** Health Plans in California are required by law to provide certain mental health services according to the same terms and conditions as other similar medical benefits. Please contact the individual plan for further information regarding the conditions subject to mental health parity.
(*3)** Hospice benefits are available through the plan. Please consult plan's Evidence of Coverage.